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Legal barriers to access abortion services through a human rights lens: the Uruguayan experience

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Abstract: Sexual and reproductive health (SRH) has increasingly gained importance in the field of international human rights law. The work of the United Nations (UN) bodies, in particular the recently adopted General Comment 22 (GC 22), has been instrumental in signalling the importance of the SRH legal framework and in setting clear guidelines to steer countries into enacting/modifying/repealing national laws in order to comply with their international obligations vis-à-vis SRH. Although within the region Uruguay is regarded as a pioneer in terms of women's status and rights, including sexual and reproductive health and rights, evidence points to a number of challenges. This article explores the extent to which the Uruguayan abortion law complies with the country's international human rights obligations as conceptualised by GC 22. It uses the Uruguayan abortion law, its regulatory decree, and the highest administrative court's decision in *Alonso et al v. Poder Ejecutivo* as the main pivots for the discussion. The results reveal that – in spite of the praise it receives at the international level and the adoption of a less restrictive abortion law – Uruguay has fallen short in adopting a legal framework that complies with the international standards and guarantees effective access to abortion services. DOI: 10.1080/09688080.2017.1422664

Keywords: abortion, law, Uruguay, barriers to access, human rights

Introduction

Uruguay gained international praise in 2012 when it passed one of the most liberal abortion laws of the continent. While the law undoubtedly represents a step in the right direction, the procedural provisions demand a closer look. A crucial step toward the fulfilment of the rights relating to sexual and reproductive health (SRH) is the removal of any legal barriers thereto.¹ Thus, a critical analysis of the Uruguayan legal framework in light of human rights standards is essential for the further modification and advancement of these rights in practice. This article will use international human rights law – especially the recent General Comment No. 22 (GC 22)¹ – as a framework to discuss the

aforementioned law and whether the requirements contained therein form a barrier to women's access to reproductive health services, violating their basic rights.²

The legal framework in Uruguay

With a stable democracy and a longstanding tradition of respect for human rights, Uruguay is considered a pioneer in the Latin American context.³ The country is a party to all relevant international instruments that ground SRH and has shown a strong political commitment to work toward the effective enjoyment of sexual and reproductive rights.

Research conducted during the period 1997–2001 shows that although the maternal mortality rates of Uruguay were similar to those of comparably developed countries, death from unsafe abortion was the main contributor and among the highest in the world. Unsafe abortion accounted for 28% of total maternal deaths, disproportionately affecting women in vulnerable situations.⁴

¹General Comments are interpretations of the human rights treaties made by the treaty monitoring bodies. Some scholars point at the quasi-legislative character of these comments in the sense that they guide States in the fulfilments of their obligations and serve as an authoritative interpretation of the provisions of treaties.

In response to UN bodies' concerns about the high incidence of maternal mortality and its main cause being unsafe abortion, in 2011 Uruguay introduced a "harm-reduction" approach.⁵ This approach consisted of providing women seeking abortions with a "before-abortion" and an "after-abortion" visit to a reproductive health polyclinic. The application of this model contributed to the advancement of sexual and reproductive health and rights (SRHR), particularly regarding prevention of unsafe abortion.⁶ It enabled health-care teams to take a stance in favour of women's rights, even within an extremely restrictive abortion framework.

From 1907 to 2012 abortion was considered a crime in Uruguay and the law imposed a three- to nine-year prison sentence on women undergoing abortions.⁷ Nonetheless, this illegality did not have any deterrent effect: an estimated 30,000 to 50,000 clandestine abortions were still performed yearly.⁸ In 2002, there was an attempt to end criminalisation when an abortion legalisation bill was discussed in and passed by the House of Representatives. The bill was, however, later defeated in the Senate by only four votes. A new initiative was undertaken in 2006 and, in late 2007 and in 2008, approved by the Senate and the House of Representatives, respectively. This time the president in power vetoed the law.⁹

In 2012, the Voluntary Termination of Pregnancy Act (Abortion Law N° 18.987) was adopted. One month later, Regulatory Decree 375/2012 was introduced, containing further details in relation to abortion. The law waives criminal penalties for abortion in the first 12 weeks of gestation, provided certain procedural requirements are met. Where the pregnancy results from rape, abortion is permitted in the first 14 weeks of gestation. No time constraints apply if the health of the mother is endangered or the embryo is unviable.

The abortion law has since been the target of many legal and political challenges. In June 2013, anti-abortion advocates attempted to overturn it by calling for a referendum that, in the end, fell significantly short of the percentage-threshold needed to succeed.¹⁰ Moreover, in July 2013, several doctors challenged Decree 375/2012, arguing that it unduly restricts their right to freedom of thought. When doing so, the doctors sought to have 10 out of the 42 articles included in the Decree annulled (*Alonso et al v. Poder*

Ejecutivo). On 21 August 2015, the highest administrative court effectively annulled several of the provisions that limit the exercise of conscientious objection (CO).¹¹

Human rights standards and legal barriers to accessing abortion services

Sexual and reproductive health-related rights have been increasingly recognised and elaborated in international human rights law. The UN human rights system has repeatedly confirmed these rights as human rights, first enshrined under the right to health in the International Covenant on Economic, Social, and Cultural Rights.¹²

The International Conference on Population and Development (ICPD) (Cairo, 1994) transformed the discourse from reproductive control as a strategy to meet demographic targets and control population growth to a more comprehensive and positive approach to sexuality and reproduction. ICPD forged the link between sexuality and health as human rights, where women's agency over their own bodies and sexuality is intrinsically linked to their SRH.¹³ The Beijing Platform for Action expanded the ICPD definition to cover both sexuality and reproduction by upholding the right to exercise control over and make decisions about one's sexuality.¹⁴ Among their many achievements, these documents recognised the duty of governments to legislate on the matter, translating international commitments into national laws and policies.¹⁵

In March 2016, the Committee on Economic, Social, and Cultural Rights adopted GC 22, aiming to assist State parties with the implementation of their international obligations to realise SRH.² Among others, GC 22 affirms that states have an obligation to adopt "appropriate legislative" measures in order to achieve the full realisation of SRH. Other UN bodies, such as the Convention on the Elimination of all Forms of Discrimination Against Women Committee (CEDAW), have also recognised that legal arrangements are key to realise SRHR and warn of the dangers of "inadequate" laws.¹⁶ For example, the Committee has noted how the "inadequacy of the existing law on abortion contributed to the problem" of high rates of maternal mortality due to unsafe abortions being carried out.¹⁷ For that reason, the UN bodies have recommended that states be proactive in the adoption of a legal framework on SRHR.¹⁸

According to GC 22, states have an obligation to repeal or eliminate laws, policies, and practices that criminalise, obstruct, or undermine individuals' or particular groups' access to SRH facilities, services, goods, and information. This, as the GC makes clear, is a "core obligation" – one that is deemed two-fold in this analysis.

Obligation to reform laws that impede the exercise of the right to SRH and immediate obligation to eliminate discrimination

On one hand, GC 22 affirms that states are under an "immediate obligation" to eliminate discrimination against individuals and groups, and to guarantee their equal right to SRH. The GC outlines that the realisation of women's rights and gender equality requires states to repeal or reform any discriminatory laws, policies, and practices in this area. Laws that criminalise or restrict abortion are cited by GC 22 as examples of laws that must be repealed.²

The CEDAW Committee has also recommended taking steps toward the decriminalisation of abortion, requiring countries to modify or repeal the existing abortion legislation to fit with obligations assumed internationally.¹⁹ The former Special Rapporteur on the Right to Health, Anand Grover, has argued that "[c]riminal laws penalizing and restricting induced abortion are the paradigmatic examples of impermissible barriers... and must be eliminated".²⁰

Obligation to remove and refrain from enacting laws and policies that create barriers in access to SRH services

On the other hand, states are required to remove and refrain from enacting laws and policies that create barriers in access to SRH services. GC 22 explicitly addresses the duty to remove all barriers interfering with women's access to reproductive health services.²

Concretely, in relation to the tripartite typology in human rights, GC 22 establishes that the *duty to respect* requires states to refrain from interfering with individuals' exercising their SRH rights. Examples include limiting or denying access to health services and information, through laws or practices that criminalise abortion or that require third-party authorisation for access to abortion or contraception, among others. Under the *obligation to protect*, states must protect individuals' SRH-related rights from interference by third parties, such as private health clinics, or insurance

companies that impose practical or procedural barriers to health services. The *obligation to fulfill*, in turn, also requires states to take measures to eradicate practical barriers to the full realisation of SRH-related rights, such as disproportionate costs and lack of physical or geographical access to SRH care.²

In *L.C. v. Peru*, the CEDAW Committee noted that since the State Party had legalised therapeutic abortion, it must establish an appropriate legal framework that allows women to exercise their right thereto. The Committee built on the considerations made by the European Court of Human Rights that read "[o]nce the legislature decides to allow abortion, it must not structure its legal framework in a way which would limit real possibilities to obtain it".²¹ The UN Human Rights Committee also leaves no room for doubt: "in cases where abortion procedures may lawfully be performed, all obstacles to obtaining them should be removed".²² Furthermore, the Special Rapporteur on Torture has indicated that the denial of legally available health services – such as abortion and post-abortion care – can cause tremendous and lasting physical and emotional suffering that can amount to torture or ill treatment.²³

The decriminalisation/liberalisation of abortion and the elimination of barriers in access thereto are therefore also deemed vital to ensure compliance with other core obligations set forth by GC22: the obligation to prevent unsafe abortions.²

Legal barriers to access abortion services in Uruguayan law

Besides the general obligations delineated above, the UN system has grappled with an extensive list of specific barriers and created clear guidelines to assist countries in enacting/modifying/repealing national laws so as to comply with their international obligations regarding SRH. While the Uruguayan legal framework on SRH and abortion represents an important step toward the realisation of these rights, a closer look reveals a number of burdensome requirements that must be fulfilled by the woman seeking access to the abortion service. This section assesses some of these requirements in light of the human rights standards discussed in the previous section.

First of all, it is noteworthy that abortion remains a crime under Uruguayan law; the abortion law merely waived criminal punishment when abortion is performed under very specific

circumstances and after complying with an extensive list of requirements. For some of the actors involved in the parliamentary discussion, this legislative amendment brought no real change as the voluntary termination of pregnancy continues to fall within the ambit of penal law.²⁴ Hendriks notes that the exposure of women to human rights violations as well as to health damage is often perpetuated by criminal laws, which represent the most onerous, intrusive, and punitive of state powers and should be invoked only where it offers a necessary and proportionate means to achieve an important objective.²⁵ Thus, the Uruguayan abortion law – although it represents a step toward a more liberal approach – falls short of the obligation to repeal or reform laws that impede the exercise of SRHR.

Besides the extensive criticisms related to the regulation of abortion as a criminal matter – with the pervasive stigma and negative consequences that it entails – the requirements prescribed by Uruguayan law for women seeking to lawfully access abortion services²⁶ constitute a violation of the duty to respect SRH-related rights. Under these rights, states are required to remove and refrain from enacting laws and policies that create barriers to access to SRH services.²

The abortion law presents a barrier in terms of gestational limits for abortion: lawful abortion is only available within the first 12 weeks of pregnancy. Where the pregnancy results from rape, contingent on certain procedural requirements, abortion is permitted up to 14 weeks. According to the abortion law, in order for the termination to be legal – and thus not a crime punished accordingly – the woman needs to go through the following chronological steps: (a) a medical consultation with an obstetrician/gynecologist; (b) a second consultation with an interdisciplinary team in order to inform the woman of the procedure, its “inherent health risks”, and the alternatives that exist; (c) a mandatory waiting period of five days; (d) a consultation to confirm the woman’s willingness to follow through with the procedure; (e) the abortion itself; and (f) a post-abortion consultation.²⁶

Three barriers that arise in the course of this process are described below: waiting periods, mandatory counselling, and problems related to CO.

Mandatory waiting period

As mentioned above, Uruguayan law requires a five-day mandatory waiting period: the minimum amount of time that is legally required to elapse

before a woman can continue to terminate her pregnancy.²⁷ According to the WHO, such a provision delays care, jeopardising women’s ability to access safe abortion services and demeaning them as competent decision-makers.²⁸

The Guttmacher Institute reports that qualitative assessments of experiences with waiting-period laws found that both patients and providers were burdened in multiple ways by this obligation.²⁹ A delay of days or even hours may increase medical risks by impeding earlier, safer abortions.³⁰ A study conducted in the US revealed that 70% of women who had been required to go through a waiting period before their abortion disapproved of such a delay.³¹ Similar results were obtained in relation to a 24-hour “reflection period”.³²

Furthermore, GC 22 explicitly refers to mandatory waiting periods as a barrier to be eliminated in that context.² The CEDAW Committee – in line with the recommendations of the WHO – has also requested that countries remove the requirement of waiting periods, considering them to be “medically unnecessary”. The Committee considers even a 48-hour waiting period to constitute a barrier to access that should be reviewed.³³ Thus, it urges states to ensure access to safe abortion without subjecting women to mandatory counselling and deems the imposition of these requirements to be “aimed at restricting women’s access to abortion”.³⁴

Counselling and access to unbiased information

The ICPD regards reproductive health care as including access to information, education, and counselling on human sexuality, family planning, and responsible parenthood. The Committee on Economic, Social and Cultural Rights’ General Comment 14 has framed the right to information on SRH as an essential component of the right to health.³⁵

Contrary to the UN bodies’ call for its elimination, the Uruguayan law requires multidisciplinary mandatory counselling for women seeking abortions. As described above, women are legally required to consult three professionals who are obliged to inform them of the “inherent health risks” of the abortion procedure.²⁶ The same legal obligation is not extended to information regarding pregnancy-related health risks.²⁶ The objective of this interdisciplinary counselling committee is to “contribute to overcome the causes that lead to the interruption of pregnancy”,

evidencing the deterrent intention of the provision. As mentioned earlier, Article 12 of Decree 375/2012 required physicians to refrain from making any value judgment regarding the patient's decision to terminate her pregnancy and mandated that no further inquiry into her reasons be carried out. This provision was, however, rendered null and void by the decision in *Alonso et al v. Poder Ejecutivo*.¹¹ Consequently, women have become exposed to stigmatisation or medically inaccurate (or misleading) information about abortion, putting lives at risk and forcing some women to resort to clandestine abortions.³⁶

In practice, this counselling requirement functions as a form of third-party authorisation that women need to obtain prior to accessing the service. The CEDAW Committee's General Recommendation 24 notes that conditioning women's access to health services on the authorisation of husbands, partners, parents, or health authorities is a significant barrier to the pursuit of their health goals, deterring them from seeking and receiving the information and services guaranteed by law.³⁷ The UN bodies have repeatedly called for the elimination of counselling requirements and GC 22 explicitly prohibits them.^{2,20}

The counselling prerequisite is, in other words, contrary to the obligations set by the international legal framework; GC 22 considers that state-imposed legal barriers that undermine SRH rights and/or a failure to take the measures necessary to eradicate such barriers violate the governmental obligation to fulfil these rights.²

Conscientious objection

The scope of CO is regulated generally by Law 18.987 and in more detail by the adjusted version of Decree 375/2012 following *Alonso et al*. That said, it is important to note that invoking CO has had significant and very real consequences in practice.

Research conducted by MYSU (Women and Health Uruguay) indicates that an alarming number of doctors refuse to perform abortion by raising a CO defence. Concretely, this means that healthcare professionals – and corporations – exempt themselves from providing abortion care on religious, moral, and/or philosophical grounds. MYSU's research shows that in some areas of the country up to 87% of medical service providers refuse to terminate pregnancies, making it virtually impossible to obtain timely access to services.³⁶ One study concluded that doctors are

collectively practicing official disobedience and resisting the law, thereby impeding women's access to care.³⁸

Here again, the Uruguayan framework marks a departure from the human rights standards set by international human rights law. The former, for example, introduces the notion of "ideological objection" ("objeción de ideario"), enabling private health institutions to invoke an institutional objection and abstain from providing abortion services altogether.³⁸ Moreover, the decision in *Alonso et al v. Poder Ejecutivo* enables doctors to refuse participation in any of the steps relating to the termination of pregnancy (not only the abortion procedure), hindering access to pre- and post-abortion care.¹¹

The formulation of CO provided in this framework prevents patients from receiving accurate, scientific, and unbiased information about their options, and thus inhibits their ability to access such care, clashing with the obligations assumed at the international level.³⁹ Firstly, the obligation to protect requires states to prohibit and prevent private actors from imposing practical or procedural barriers to health services.² In this regard, states must organise health services in a manner that ensures that "the exercise of CO by health professionals does not prevent women from obtaining access to health services".⁴⁰ Secondly, the CEDAW Committee clarified that "if health service providers refuse to perform such services based on CO, measures should be introduced to ensure that women are referred to alternative health providers".³⁷ According to GC 22, states must appropriately regulate this practice to ensure that it does not inhibit anyone's access to SRH care, including by requiring referrals to an accessible provider capable of and willing to provide the services being sought.² And thirdly, states must guarantee the performance of services in urgent or emergency situations.² The Uruguayan framework does not meet any of these standards.

Moreover, in July 2016, the CEDAW Committee considered the reports from Uruguay and noted its concern about the widespread use of CO among medical practitioners, "thereby limiting access to safe abortion services, which are guaranteed by law".⁴¹ It recommended that the state take active measures to ensure that women have access to legal abortion and post-abortion services, and "introduce stricter justification requirements to prevent the blanket use by medical practitioners of their right to CO to performing an abortion".⁴¹

Conclusions and perspectives for the future

Policies and laws that act as barriers to the availability, accessibility, acceptability, and quality of SRH services remain an area of serious concern worldwide. A critical analysis of the existing domestic legal framework in light of these standards is crucial for the further modification and advancement of these rights in practice. This article reveals that – in spite of its praise at the international level and the adoption of a less restrictive abortion law – Uruguay has fallen short of adopting a legal framework that complies with international standards and that guarantees effective access to abortion services. The requirements set by the law not only violate the obligations to eradicate barriers, limiting women's access to lawful services, but also result in inequities in access and create disproportionate risks for poor women, young women, ethnic minorities, and other women in vulnerable positions. After all, these women often do not have the resources – time, money, transportation means – and knowledge to face all the obstacles required by law.³⁶ Moreover, these barriers make access unduly burdensome for women who experience gender-based violence or sexual violations, and

who are twice as likely to need abortion services as women who do not experience such violence.⁴²

Fortunately, the shortcomings of the Uruguayan legal framework have reached the parliament and a draft that eliminates many of the above-mentioned barriers has been submitted. In the wake of legal reform, it is important that law-makers, as well as health and human rights advocates, follow these developments carefully in order to keep compliance with the international human rights framework in mind. States Parties should, after all, be guided by contemporary human rights instruments and jurisprudence, as well as the most up-to-date international guidelines and protocols established by the UN agencies.

The Uruguayan “harm-reduction” approach has been replicated in different countries, successfully reducing maternal mortality rates and promoting SRHR and gender equality. Although legal solutions are not so easily transplantable, Uruguay now has the chance to bring the abortion law in line with global human rights standards. And by doing so, it can continue to be an SRHR champion serving again as a model, this time to advance law and policy reform in the region.

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Résumé

La santé sexuelle et procréative a acquis de plus en plus d'importance dans le droit international relatif aux droits de l'homme. Le travail des organes des Nations Unies, en particulier l'observation générale n°22 récemment adoptée [par le Comité des droits économiques, sociaux et culturels], a été déterminant pour signaler l'importance du cadre juridique de la santé sexuelle et génésique et pour définir des directives claires qui aident les pays à promulguer/modifier/abroger des lois nationales afin de respecter leurs obligations internationales dans ce domaine. Même si, dans sa région, l'Uruguay est considéré comme un pionnier du point de vue de la condition et des droits de la femme, y compris la santé et les droits sexuels et génésiques, les données mettent en évidence plusieurs obstacles. Cet article étudie dans quelle mesure la loi uruguayenne sur l'avortement respecte les obligations internationales du pays en matière de droits de l'homme telles que conceptualisées dans l'observation générale. Il se sert de la législation uruguayenne sur l'avortement, de son décret d'application et de la décision de la plus haute cour administrative dans l'affaire *Alonso et al* contre le Pouvoir exécutif comme principaux axes de la discussion. Les résultats révèlent que, malgré les louanges qu'il reçoit au niveau international et l'adoption d'une loi moins restrictive sur l'avortement, l'Uruguay n'est pas parvenu à adopter un cadre qui observe les normes internationales et garantisse un accès véritable aux services d'avortement.

Resumen

La salud sexual y reproductiva (SSR) cada vez más ha ganado importancia en el campo del derecho internacional de los derechos humanos. El trabajo de los organismos de las Naciones Unidas (ONU), en particular la Observación General 22 (OG 22) adoptada recientemente, ha sido fundamental para señalar la importancia del marco legislativo relativo a la SSR y para establecer directrices claras que dirijan a los países hacia promulgar/modificar/revocar las leyes nacionales, con el fin de que cumplan con sus obligaciones internacionales en materia de SSR. Aunque dentro de la región Uruguay es considerado como pionero en la condición social y jurídica y los derechos de la mujer, incluidos la salud y los derechos sexuales y reproductivos, la evidencia indica varios retos. Este artículo explora en qué medida la ley uruguaya relativa al aborto cumple con las obligaciones del país con respecto a los derechos humanos internacionales, conceptualizadas en la OG 22. Utiliza dicha ley, su decreto reglamentario y la decisión del tribunal administrativo supremo en *Alonso Justo y otros contra Poder Ejecutivo* como los principales ejes del debate. Los resultados revelan que – a pesar de los elogios que recibe a nivel internacional y la adopción de una ley sobre aborto menos restrictiva – Uruguay no ha llegado a adoptar un marco legislativo que cumpla con las normas internacionales y garantice acceso eficaz a los servicios de aborto.